Complete Summary

TITLE

Preventive care and screening: percentage of patients 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.

SOURCE(S)

Physician Consortium for Performance Improvement® (PCPI). Preventive care & screening physician performance measurement set. Chicago (IL): American Medical Association (AMA); 2008 Sep. 34 p. [8 references]

Measure Domain

PRIMARY MEASURE DOMAIN

Process

The validity of measures depends on how they are built. By examining the key building blocks of a measure, you can assess its validity for your purpose. For more information, visit the Measure Validity page.

SECONDARY MEASURE DOMAIN

Does not apply to this measure

Brief Abstract

DESCRIPTION

This measure is used to assess the percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.

RATIONALE

There is good evidence that tobacco screening and brief cessation intervention (including counseling and pharmacotherapy) in the primary care setting is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

The following evidence statements are quoted verbatim from the referenced clinical guidelines:

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. (USPSTF, 2003)

During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use. (National Quality Forum [NQF], 2007)

All patients should be asked if they use tobacco and should have their tobacco-use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (U.S. Department of Health & Human Services-Public Health Service, 2008)

All *physicians* should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (U.S. Department of Health & Human Services-Public Health Service, 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention whether or not he or she is referred to an intensive intervention. (U.S. Department of Health & Human Services-Public Health Service, 2008)

PRIMARY CLINICAL COMPONENT

Tobacco use; screening; cessation counseling intervention

DENOMINATOR DESCRIPTION

All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the two year measurement period (see the related "Denominator Inclusions/Exclusions" field in the Complete Summary)

NUMERATOR DESCRIPTION

Patients who were screened for tobacco use at least once during the two-year measurement period AND who received tobacco cessation counseling intervention if identified as a tobacco user (see the related "Numerator Inclusions/Exclusions" field in the Complete Summary)

Evidence Supporting the Measure

EVIDENCE SUPPORTING THE CRITERION OF QUALITY

- A clinical practice guideline or other peer-reviewed synthesis of the clinical evidence
- One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

NATIONAL GUIDELINE CLEARINGHOUSE LINK

- Counseling to prevent tobacco use and tobacco-caused disease: recommendation statement.
- Treating tobacco use and dependence: 2008 update.

Evidence Supporting Need for the Measure

NEED FOR THE MEASURE

Overall poor quality for the performance measured
Variation in quality for the performance measured

EVIDENCE SUPPORTING NEED FOR THE MEASURE

Asch SM, Kerr EA, Keesey J, Adams JL, Setodji CM, Malik S, McGlynn EA. Who is at greatest risk for receiving poor-quality health care. N Engl J Med2006 Mar 16;354(11):1147-56. [32 references] PubMed

Physician Consortium for Performance Improvement® (PCPI). Preventive care & screening physician performance measurement set. Chicago (IL): American Medical Association (AMA); 2008 Sep. 34 p. [8 references]

State of Use of the Measure

STATE OF USE

Current routine use

CURRENT USE

Internal quality improvement

Application of Measure in its Current Use

CARE SETTING

Ambulatory Care
Physician Group Practices/Clinics

PROFESSIONALS RESPONSIBLE FOR HEALTH CARE

Physicians

LOWEST LEVEL OF HEALTH CARE DELIVERY ADDRESSED

Individual Clinicians

TARGET POPULATION AGE

Age 18 years and older

TARGET POPULATION GENDER

Either male or female

STRATIFICATION BY VULNERABLE POPULATIONS

Unspecified

Characteristics of the Primary Clinical Component

INCIDENCE/PREVALENCE

In 2006, approximately 20.8% (45.3 million) U.S. adults were current smokers. There has not been a significant change in this prevalence since 2004.

During 1997 to 2001, approximately 438,000 premature deaths each year were attributed to smoking or exposure to second hand smoke.

The 2006 National Survey on Drug Use and Health (NSDUH) found that approximately 72.9 million (29.6%) Americans age 12 years and older were current users of tobacco. A breakdown by type of tobacco is as follows:

- 61.6 million persons (25.0%) were current cigarette smokers
- 13.7 million persons (5.6%) smoked cigars
- 8.2 million persons (3.3%) use smokeless tobacco
- 2.3 million (0.9%) smoked tobacco in a pipe

EVIDENCE FOR INCIDENCE/PREVALENCE

Centers for Disease Control and Prevention (CDC). Annual smoking-attributable mortality, years of potential life lost, and productivity losses--United States, 1997-2001. MMWR Morb Mortal Wkly Rep2005 Jul 1;54(25):625-8. PubMed

Centers for Disease Control and Prevention (CDC). Cigarette smoking among adults--United States, 2004. MMWR Morb Mortal Wkly Rep2005 Nov 11;54(44):1121-4. PubMed

Centers for Disease Control and Prevention (CDC). Cigarette smoking among adults--United States, 2006. MMWR Morb Mortal Wkly Rep2007 Nov 9;56(44):1157-61. PubMed

Substance Abuse and Mental Health Services Administration (SAMHSA). Results from the 2006 National Survey on Drug Use and Health: National Findings [Office of Applied Studies, NSDUH Series H-32, DHHS Publication No. SMA 07-4293]. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2007. 282 p.

ASSOCIATION WITH VULNERABLE POPULATIONS

Unspecified

BURDEN OF ILLNESS

See the "Rationale" field.

UTILIZATION

Unspecified

COSTS

Smoking attributable health care expenditures in 1998 were estimated to be $75.5 billion. This, plus the estimated productivity losses of $92 billion from 1997 to 2001 combine for a total of over $167 billion per year.

EVIDENCE FOR COSTS

Centers for Disease Control and Prevention (CDC). Annual smoking-attributable mortality, years of potential life lost, and productivity losses--United States, 1997-2001. MMWR Morb Mortal Wkly Rep2005 Jul 1;54(25):625-8. PubMed

From the Centers for Disease Control and Prevention. Annual smoking attributable mortality, years of potential life lost and economic costs--United States, 1995-1999. JAMA2002 May 8;287(18):2355-6. PubMed

Institute of Medicine National Healthcare Quality Report Categories

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

Data Collection for the Measure

CASE FINDING

Users of care only

DESCRIPTION OF CASE FINDING

All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the two year measurement period

DENOMINATOR SAMPLING FRAME

Patients associated with provider

DENOMINATOR INCLUSIONS/EXCLUSIONS

Inclusions
All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the two year measurement period

Note: Refer to the original measure documentation for administrative codes.

Exclusions
Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy)

RELATIONSHIP OF DENOMINATOR TO NUMERATOR

All cases in the denominator are equally eligible to appear in the numerator

DENOMINATOR (INDEX) EVENT

Encounter

DENOMINATOR TIME WINDOW

Time window is a single point in time

NUMERATOR INCLUSIONS/EXCLUSIONS

Inclusions
Patients who were screened for tobacco use* at least once during the two-year measurement period AND who received tobacco cessation counseling intervention** if identified as a tobacco user

*Includes use of any type of tobacco

**Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy

Note: Refer to the original measure documentation for administrative codes.

Exclusions
None

MEASURE RESULTS UNDER CONTROL OF HEALTH CARE PROFESSIONALS, ORGANIZATIONS AND/OR POLICYMAKERS

The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.

NUMERATOR TIME WINDOW

Encounter or point in time

DATA SOURCE

Administrative data
Medical record

LEVEL OF DETERMINATION OF QUALITY

Individual Case

PRE-EXISTING INSTRUMENT USED

Unspecified

Computation of the Measure

SCORING

Rate

INTERPRETATION OF SCORE

Better quality is associated with a higher score

ALLOWANCE FOR PATIENT FACTORS

Unspecified

STANDARD OF COMPARISON

Internal time comparison

Evaluation of Measure Properties

EXTENT OF MEASURE TESTING

Unspecified

Identifying Information

ORIGINAL TITLE

Measure #1: tobacco use: screening & cessation intervention.

MEASURE COLLECTION

The Physician Consortium for Performance Improvement® Measurement Sets

MEASURE SET NAME

SUBMITTER

American Medical Association on behalf of the Physician Consortium for Performance Improvement®

DEVELOPER

Physician Consortium for Performance Improvement®

FUNDING SOURCE(S)

Unspecified

COMPOSITION OF THE GROUP THAT DEVELOPED THE MEASURE

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FINANCIAL DISCLOSURES/OTHER POTENTIAL CONFLICTS OF INTEREST

Conflicts, if any, are disclosed in accordance with the Physician Consortium for Performance Improvement® conflict of interest policy.

ADAPTATION

Measure was not adapted from another source.

RELEASE DATE

2003 Oct

REVISION DATE

2008 Sep

MEASURE STATUS

This is the current release of the measure.

This measure updates a previous version: Physician Consortium for Performance Improvement®. Clinical performance measures: preventive care and screening. Tools developed by physicians for physicians. Chicago (IL): American Medical Association (AMA); 2005. 13 p. [11 references]

SOURCE(S)

Physician Consortium for Performance Improvement® (PCPI). Preventive care & screening physician performance measurement set. Chicago (IL): American Medical Association (AMA); 2008 Sep. 34 p. [8 references]

MEASURE AVAILABILITY

The individual measure, "Measure #1: Tobacco Use: Screening & Cessation Intervention," is published in the "Preventive Care & Screening Physician Performance Measurement Set." This document and technical specifications are available in Portable Document Format (PDF) from the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement® Web site: www.physicianconsortium.org.

For further information, please contact AMA staff by e-mail at cqi@ama-assn.org.

NQMC STATUS

This NQMC summary was completed by ECRI on February 26, 2004. The information was verified by the measure developer on September 13, 2004. This NQMC summary was updated by ECRI on September 28, 2005. The information was verified by the measure developer on November 8, 2005. This NQMC summary was updated again by ECRI Institute on February 13, 2009. The information was verified by the measure developer on March 25, 2009.

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